Letters

CMAJ publishes as many letters as possible. However, since space is limited, choices have to be made, on the basis of content and style; we routinely correspond only with authors of accepted letters. Letters that are clear, concise and convenient to edit (no longer than two double-spaced typescript pages, or 450 words) are more likely to be accepted. Those that are single-spaced, handwritten or longer than 450 words will usually not be published, without comment to the author or return of the letter; nevertheless, we reserve the right to abridge letters that are unduly long or repeat points made in other letters, especially in the same issue, as well as to edit for clarity.

Cost containment: informing patients

I read with great interest Amy Chouinard's "CMA leadership conference: MDs must recognize that resources are limited" (*Can Med Assoc J* 1989; 140: 960, 962–963).

I have no difficulty living in the new era of cost containment and being continually cost conscious in my practice. Nor do I object to taking part in the rationing of services and seeing my patients get less than optimal care because there is no money available.

What I object to, however, is doing all this without the patients' knowledge. I believe that patients must have full knowledge of all the decisions we make in respect to their treatment.

In the past the international nephrology community criticized our British colleagues because they refused dialysis to patients older than 55 years, offering medical reasons for not providing the treatment and not acknowledging the real reason: cost containment.

When we inform patients, the problem of limited resources no longer is a problem between government and the medical profession but becomes a problem for the whole society; in turn, society will decide whether it will tolerate this situation or will bring about changes through its elected representatives.

The medical profession has an obligation to work with government and hospital administration in appropriately allocating limited resources, but under no circumstances should these decisions be hidden from the patients.

Dimitrios G. Oreopoulos, MD, PhD, FRCPC, FACP
Professor of medicine
University of Toronto
Director
Peritoneal Dialysis Unit
Toronto Western Hospital
Toronto, Ont.

Boycotting pharmacies that sell tobacco products

I think that the CMA should try to educate people about the harmful effects of smoking, but I cannot agree with the attempted boycott of pharmacies that sell tobacco products. It is not the pharmacies' responsibility to make ethical decisions regarding legal products.

How would the CMA respond if the Canadian Pharmaceutical Association recommended a boycott of physicians who smoke?

Norman Pinsky, MD
3635 Dutch Village Rd.
Halifax, NS

[See Patrick Sullivan's article "CMA targets drugstores in latest antismoking drive" in the July 1, 1989, issue of CMAJ *(141: 66), which was in press when this letter arrived. — Ed.]*

Prevention in the era of high-tech medicine

I found Dr. Calvin R. Stiller's article "High-tech medicine and the control of health care costs" (*Can Med Assoc J* 1989; 140: 905–908) thought provoking.

It is my understanding that all transplantation programs suffer from a shortage of organs for transplantation. The demand still exceeds the supply, and there will be a cost for achieving a greater supply of suitable material no matter what the mechanism. There is also a significant failure rate for any transplant procedure, although the rates have been reduced, in some cases dramatically, over the last several years.

Many if not all diseases that may necessitate organ transplantation are a result of a number of factors, many of which are unknown but some of which are preventable. The literature is replete with examples of diseases caused by dietary deficiencies; similarly, there is much evidence linking the ingestion of toxic substances — alcohol,[1] for example